APPEAL NO. 93435

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1993). On May 7, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine the issue of claimant's correct average weekly wage (AWW), and his correct impairment rating resulting from a spine and shoulder injury sustained by the claimant, who is the appellant in this appeal. The carrier was not present at the hearing. The claimant was injured on (date of injury), , while employed by (employer) at the location of (employer). The hearing officer determined that claimant's correct AWW was $370 per week, and this determination has not been appealed. The hearing officer further determined that the report of the designated doctor should be adopted and found that claimant's impairment rating was seven percent.

The claimant has appealed this decision, arguing that: 1) it was error for the hearing officer to find that claimant was an employee of (employer)., because this was not in issue and there was no evidence that this was the case; 2) that it was error for the hearing officer to consider the designated doctor's report because it had not been offered into evidence by anyone; and 3) that the hearing officer erred in not finding that the designated doctor's report "as to maximum medical improvement, impairment and pain" was not overcome by the great weight of contrary evidence. As part of the argument on the last point, the claimant asserts that there was no "dispute" leading to the appointment of Dr. H as a designated doctor, and that Dr. H failed to take into account the claimant's shoulder injury in arriving at his impairment rating. The carrier has not filed a response.

DECISION

We reverse the hearing officer's decision and render a decision that the great weight of other medical evidence is against the designated doctor's impairment rating. Because the only other impairment rating in the case has been rendered by a doctor who also stated that claimant had not reached maximum medical improvement (MMI), we render a decision that claimant is entitled to temporary income benefits (TIBS) until he reaches MMI or until disability ends, whichever occurred sooner. We note that in the absence of an appeal, the hearing officer's determination relating to claimant's AWW is final.

Claimant stated he injured his shoulder and back on (date of injury), while working as a roughneck. Medical records and testimony indicate that claimant was working alone on a slipstool, and had immediate pain in his back and shoulder after one jerk of some heavy apparatus. He was unable to work, and his parents came and took him to the emergency room.

The benefit review conference report shows that the employer was (employer). Some of the doctors' reports show the employer as (employer). Claimant stated that he "received payment" from (employer), Inc., and he worked for (employer) on the date of injury.

Claimant was ultimately treated for an injured shoulder and back by (Dr. D). He stated that Dr. D had prescribed medication, a back brace, and a TENS unit. He was also referred to (Dr. W) for some treatment of emotional problems, and said he saw Dr. W twice. The claimant agreed that surgery had been recommended to him, but that he had not had surgery because he was scared to have it. The claimant testified that he still experiences pain and has limited range of motion; the transcript reflects that he demonstrated some of his movements. Only one movement was verbally described, which was his inability to raise the elbow of the affected upper extremity higher than chest height.

The hearing officer took official notice of the report of the designated doctor, (Dr. H), over objection from the claimant's attorney. The sole basis for objection was that no one had offered it into evidence. The claimant subsequently testified that he saw Dr. H for about three minutes. The report states that claimant reached MMI on June 30, 1992, with a seven percent permanent impairment. The designated doctor commented upon both the claimant's back and shoulder in his text. He noted objective abnormalities in claimant's spine (as shown by MRI), and a lack of objective findings of shoulder abnormality (as shown by February 19, 1992 arthrogram). In the portion of the sparse narrative that discussed the spinal injury, Dr. H noted that claimant had decreased range of motion, but attributed this to pain, not any lesion. The only comment on claimant's shoulder was the single observation that claimant did not have a rotator cuff tear according to the arthrogram. Dr. H noted that claimant "may well benefit from a lumbar surgical procedure" but that if it is not performed, claimant "has" reached MMI. Dr. H indicated that he used the AMA Guides to the Evaluation of Permanent Impairment (Guides) to derive his rating, but did not otherwise indicate the basis for the seven percent rating. There is a November 16th date stamp on the report. No other documents relating to the appointment of Dr. H as a "designated doctor" are in evidence. No objection was raised at the hearing that Dr. H was <u>not</u> a designated doctor, however.

Records describing the course of claimant's treatment were entered into evidence. A necessarily concise summary follows:

6/13/91: (Dr. B) wrote a letter to carrier and recited the history of injury. Diagnosis was listed as acute low back strain with suspected herniated disc, and suspected internal disruption of the left shoulder. Claimant was taken off work. The letter indicated that Dr. B's practice was orthopedic surgery, and that he practiced with Dr. D.

6/25/91: MRI of lumber spine. Impression: Bulging at L3 with a normal appearing disc. Degenerative disc at L4 and L5 with evidence of disc herniation. Report noted that MRI of shoulder could not be obtained because of patient's large size.

7/24/91: (Dr. G) noted complaints of pain in left shoulder and back. Claimant unable to take off shoes without great difficulty. Pain to palpation, limited range of motion.

8/21/91, 9/25/91, 10/23/91, 11/20/91: Dr. G noted that claimant continued to complain of considerable left shoulder and back pain. MRI of back showed herniated disc. MRI of shoulder recommended.

12/30/91: Dr. G related that MRI of left shoulder showed Grade III impingement syndrome with a partial thickness tear of the supraspinous tendon. Claimant referred to Dr. D.

1/21/92: Dr. D noted that claimant is 23; recited history of injury and the tests performed so far. Range of motion examination done with goniometer, and limitations noted. Noted that claimant has not gone to therapy, but had taken medication. Myelogram and EMG ordered. Dr. D diagnosed herniated disc, left shoulder rotator cuff tear.

2/18/92: Dr. H, reporting on radiological studies, noted that myelogram, left shoulder and lumbosacral spine are normal.

2/19/92: Shoulder arthrogram normal.

2/25/92: Dr. D noted that shoulder arthrogram is normal. Commented on previous December 1991 MRI showing a partial thickness tear. Noted that claimant had EMG this month showing mild peripheral neuropathy. Tenderness from myelogram reported. Complaints of continued pain noted. Dr. D continued to keep claimant off work.

3/31/92: Dr. D stated that claimant had a normal lumbar myelogram. Noted that claimant will eventually require arthroscopy for shoulder and/or surgery for his lower back. Physical impairment to spine opined to be 20% to 40% of his body, and shoulder 40% of upper extremity. Claimant totally restricted from light and heavy manual labor.

4/29/92: Dr. G noted impression of left shoulder rotator cuff tear and herniated disc at L3-4 and L5. Stated that claimant is ready for surgery and he will schedule him; noted that conservative therapy will continue. Continued complaints of shoulder and back pain noted; spinal range of motion conducted.

5/26/92: Dr. D noted that claimant hadn't changed and kept him off work.

6/30/92: Dr. D noted that claimant still complains of neck and back pain. Range of motion of spine and shoulder observed. Recommended new MRI of lumbar spine, and noted that claimant "still" needs physical therapy. Dr. D also recommended psychological counselling for claimant's depression resulting from his injuries. Dr. D noted that claimant still hasn't reached "maximum physical improvement" but that physical impairment of the "right" shoulder is "50% of his extremity" and his back is into "16% of his body." There is some indication at the end of this note that recommended treatment programs have not been "allowed."

7/27/92: Dr. D noted that claimant had trouble getting out of his chair, held shoulder to his side, and walked with antalgic gait. Range of motion with goniometer conducted.

9/8/92: Dr. D stated that claimant had MRI, indicating disc bulging at L4-5 and L5-S1, with a herniation at L3-4. Continued diagnosis of rotator cuff tear of the shoulder. Dr. D noted that "someone" gave claimant an eight percent impairment rating, with which Dr. D disagreed, noting that a minimum impairment, not including the shoulder, would be 21%. Claimant is characterized as permanently out of the work force. Limited movement of left shoulder noted.

10/13/92: Dr. D put permanent restriction on claimant's activity, and characterized claimant as "100% disabled from any form" of heavy or light manual labor. Referred to recent MRI conducted in July 1992. Restrictions placed on claimant's ability to lift and bend. Recommended that claimant will have to lie down periodically during the day.

Dr. D completed two TWCC-69s, on dates not clear from the record. Both reports stated that the claimant had not reached MMI, but both assigned impairment ratings. One stated that the impairment is in the range of 20-40%.

A more complete TWCC-69 by Dr. D recited claimant's medical history and tests. It stated "[a]lso he is felt to have permanent disability from degenerative disc disease, two levels, and shoulder impingement. He hasn't reached maximum physical improvement. He hasn't been adequately tested and treated." This report has circles drawn around both the "no" and "yes" boxes in answer to the form's question asking whether the employee has reached maximum medical improvement. Next to the "yes" blank is the date "6-30-92," and 50% impairment is assigned. At the bottom, ratings were assigned to body parts: "lumbar spine- 16% of whole; upper extremity-left shoulder- 50% of upper extremity." Also noted is that a comparison of claimant's spinal "7-14-92" MRI with prior study of 6-25-91 "shows little or no change."

Results of the second MRI are not in the record. None of the medical records indicated that claimant's complaints were subjective in origin.

The carrier's representative did not attend the hearing, and the hearing officer went forward. After the hearing ended, the carrier's representative arrived, and the hearing officer reopened the record to consider whether there was good cause for failure to attend. She determined that there was not, and declined therefore to reopen the hearing. Her determination was not appealed.

Whether the Hearing Officer Erred in Finding that (employer)., was Claimant's Employer on the Date of Injury.

As claimant correctly notes, there was no issue about the identity of claimant's employer on the date of injury. We find no error when a hearing officer makes findings on undisputed issues relating to the identity of an employer or carrier. A essential finding to impose liability on the carrier for an order in this case is that its insured was the claimant's employer. A benefit review conference report, describing (employer)., as employer does not appear to have been disputed by the claimant as an inaccurate characterization of the relationship. Even if the hearing officer was in error, the claimant failed to assert how it could possibly be harmed in this proceeding by such a finding, most especially when it established liability of the carrier. Claimant's point of error is overruled.

Whether the Hearing Officer Erred in Taking Official Notice of the Report of the Designated Doctor.

A hearing officer has the responsibility to ensure full development of the facts required for the determinations to be made. 1989 Act, Article 8308-6.34(b). As the only basis for objection made was that no one had offered the report, the objection was properly disallowed, because tender of evidence by a party is not the only means by which a record may be fully developed. The hearing officer appropriately took notice of the designated doctor's report, and did not abuse her discretion by this action.[1]

Whether the Great Weight of Other Medical Evidence is Contrary to the Designated Doctor's Opinion.

The use of a designated doctor is intended under the Act to assign an impartial doctor to finally resolve disputes over MMI and/or impairment rating. To achieve this end, the report of a Commission-appointed designated doctor is given presumptive weight. Article

[1] It is probably advisable for a trier of fact to even go further in ensuring that the order appointing the designated doctor be included in the record as well.

8308-4.26(g). Only the great weight of medical evidence can reverse this presumptive status. A finding of impairment by a doctor chosen by the claimant must be confirmable by a designated doctor. Article 8308-4.25(a). As the Appeals Panel has stated before, this requires more than a mere balancing of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Lay testimony or evidence does not provide a sufficient basis to overcome this presumption. However, great weight will necessarily turn on factual considerations limited necessarily to the case at hand and should be based on the totality of the evidence. *See* Texas Workers' Compensation Commission Appeal No. 93400, decided July 7, 1993.

Claimant's contention that there was no "dispute" for the designated doctor to adjudicate and, hence, Dr. H was not a designated doctor has been raised for the first time on appeal, and will not, therefore, be addressed here.[2] Dr. H's status as designated doctor was confirmed by the hearing officer. However, as we review the totality of the medical evidence in the case, it is clear to us that the claimant has sustained significant injury to both shoulder and back. His treating doctor put him under permanent restrictions from doing manual labor. He has consistently exhibited limited range of motion of back and shoulder upon examination by Dr. B, Dr. G and Dr. D. (Dr. H concurred that range of motion for the spine was decreased). Objective testing revealed physical injuries to three levels of claimant's lumbar spine, as well as his left shoulder.

By contrast, the designated doctor's report is a brief TWCC-69 form that does not supply, in this case, needed information about the derivation of his seven percent rating. When we review Dr. H's rather sparsely completed TWCC-69, we tend to agree with the claimant's contention that Dr. H did not assess impairment for the shoulder. The apparent basis for this is a normal arthrogram, but the other medical evidence makes clear that there was also claimant's shoulder MRI, which demonstrated objective evidence of injury, but which is not mentioned in the designated doctor's report. While the Guides indicate that range of motion tests should be done on an injured shoulder, the designated doctor may not have done them because he believed, on the basis only of the arthrogram, that there was no injury. In any case, we believe that the great weight of other medical evidence supports a shoulder condition for which an impairment should be appropriately considered (or at least the failure to assign impairment should be more adequately explained).

Also, the designated doctor's report agreed that claimant had limited range of motion of the spine but declined to assess impairment for the stated reason that it was attributed to pain rather than a lesion. The designated doctor does not indicate whether he meant that

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[2] We will note that the record circumstantially indicates that the dispute over impairment might have come up based upon an assumption that Dr. D "certified" MMI effective June 30, 1992, with a 50% impairment. This is what, at a glance, his TWCC-69 appears to do; careful reading of the report, however, shows that he expressly found that claimant had not reached MMI, but was 50% impaired on June 30, 1992.

he performed range of motion examinations, which could not be accurately verified because of pain (as page 71 of the Guides indicates can be the case), or whether he declined to perform them based upon an assessment that there was no objective basis for limited range of motion. Claimant's testimony as to the brevity of the exam would seem to indicate that range of motion wasn't conducted at all.

Because the designated doctor's report appears to omit consideration of claimant's injured shoulder and lacks specific description of the basis for the seven percent rating assigned, and comparing that report to the totality of over a year's worth of claimant's medical records, we believe that the hearing officer's finding that the designated doctor's opinion as to impairment rating was not overcome by the great weight of contrary medical evidence is against the great weight and preponderance of the evidence so as to be manifestly unjust.

Article 8308-4.26(g) directs the Commission, in this situation, to adopt an impairment rating of another doctor. The only other impairment ratings in the case are either the 20-40% or the 50% ratings rendered on TWCC-69 forms by Dr. D. However, these were done in tandem with Dr. D's opinion that claimant had not reached MMI. As such, Dr. D did not certify impairment as required by the 1989 Act. *See* Article 8308-1.03(24) and (25), 4.26(c) and (d). His ratings cannot be adopted by the Commission. *See* Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993.

What we can and do adopt under the particular facts of this case, however, is Dr. D's opinion that MMI has not been reached. We recognize that MMI was not articulated as an issue. However, there is no agreement between the parties, indicated in the record, that MMI was reached. We have noted before, the two concepts are somewhat inextricably linked. Texas Workers' Compensation Commission Appeal No. 92561, decided December 4, 1992. The hearing officer found as fact that Dr. H had certified MMI, but she made no express findings or conclusions that MMI was achieved at a specific time, because the issue was cast as one only of impairment.[3] It appears, however, that she gave presumptive weight only to Dr. H's opinion on impairment rating. For purposes of argument, we will assume that his opinion on MMI may ordinarily have presumptive weight.

Under the particular facts of this case, we believe that Dr. H's opinion should be considered as a whole. Dr. H's terse opinion on MMI, related totally to back surgery, also appears to omit consideration of the effect of claimant's shoulder injury. Therefore, his conclusion relating to MMI is, under these facts, inextricably intertwined with the impairment rating we have rejected.

[3] The benefit review conference report also indicates that impairment income benefits had already been paid based upon seven percent impairment rating, thus obviating an apparent need to find a date of MMI for purposes of initiating these benefits.

Accordingly, the findings of the hearing officer are reversed as described above; in addition, we reverse the order relating to payment of twenty-one weeks of impairment income benefits, and order that carrier pay temporary income benefits to the claimant, until an ending to disability, as defined in Article 8308-1.03(16), or until he

achieves maximum medical improvement, as defined in Article 8308-1.03(32). Amounts that were paid as impairment income benefits may be credited against the temporary income benefits due for the same period, and the carrier is ordered to pay accrued temporary income benefits that are due in a lump sum, together with applicable interest.

Susan M. Kelley
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Gary L. Kilgore
Appeals Judge